



An Introduction to Just Culture

Lance Mageno, Chief Quality Officer
Carol Lucido, Education and Training Specialist

The presenters have nothing to disclose

Objectives

1. The Learner will be able to describe Just Culture and its components
2. The Learner will be able to implement Just Culture principles in the health care delivery setting



The Design of Everyday Things by Don Norman

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?”

Wrong.

The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”



Results of absence of Just Culture: Deaths Per Year

Cause
106,000 Non-error, negative effects of drugs ²
80,000 Infections in hospitals ¹⁰
45,000 Other errors in hospitals ¹⁰
12,000 Unnecessary surgery ⁸
7,000 Medication errors in hospitals ⁹

250,000 Total deaths per year from iatrogenic* causes



Introduction to Just Culture

“When I first heard of Just Culture, I didn’t know what it was, but I knew immediately that we needed it. Only later did I come to realize its simplicity, power, and effectiveness. I now believe that for any high-consequence endeavor, Just Culture must be the foundation for the organizational safety effort to succeed.”

The Honorable Robert Sumwalt, III
Vice Chairman, National Transportation Safety
Board



Elevator Speech

- A fair and just culture establishes the mechanisms to appropriately apportion responsibility – mechanisms that have both face validity and become solidly valid through the actions taken by the leadership and the community at large. In essence, a fair and just culture is one in which individuals are held accountable for their actions, but not for system flaws.



Just Culture Methodology

How to be like Mike



What is a Just Culture?

1. Just Culture supports and envelops learning
2. A Just Culture is one that learns and improves by openly identifying and examining its own weaknesses
3. Just Culture focuses on proactive management of system design and management of behavioral choices

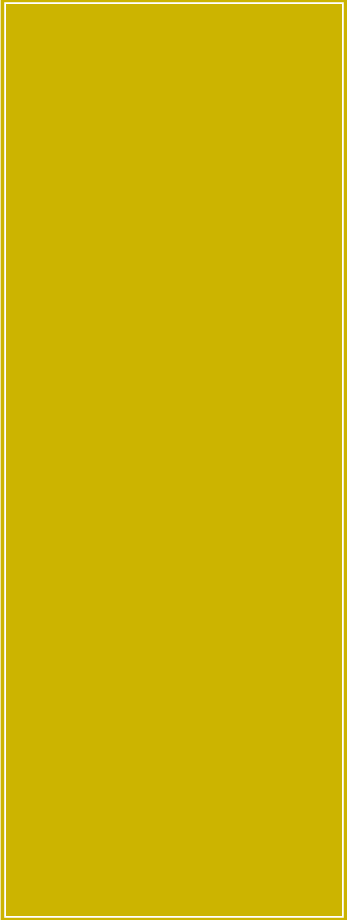


Culture of Learning

- ❖ Utilize peer review as a venue in which shared learning can occur and remove the traditional punitive focus
- ❖ Openly identifies and examines weaknesses
- ❖ Staff are able and expected to perform at peak capacity, yet at any moment be able to admit weakness or concern.



Proactive management

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- A large yellow rectangular box with a thin black border, positioned on the left side of the slide, partially overlapping the text area.
- ❖ Safety Rounds and looking for potential risks and exposing weakness
 - ❖ Highly reliable industries foster “mindfulness” in their workers.



Mindfulness

1. Constant concern about the possibility of failure even in the most successful endeavors
2. Deference to expertise regardless of rank or status
3. Ability to adapt when the unexpected occurs (commitment to resilience)
4. Ability to both concentrate on a specific task while having a sense of the bigger picture (sensitivity to operations)
5. Ability to alter and flatten hierarchy as best fits the situation ([Weick and Sutcliffe 2001](#)).

These common characteristics together appear to generate reliability

Reinforcing Our Expectations of Staff

- Looking for the risks around us
- Reporting errors and hazards
- Helping to design safe systems
- Making safe choices
 - Following procedure
 - Making choices that align with organizational values
 - Never signing for something that was not done

Just Culture and Statewide Initiatives

- Statewide collaboratives bringing together:
 - The hospitals
 - The professional boards
 - The department of health
 - Other stakeholders
- All agree in principle on one model for system and practitioner accountability
- Statewide training
- Regulatory and legislative support



Inherent System Reliability versus Culture

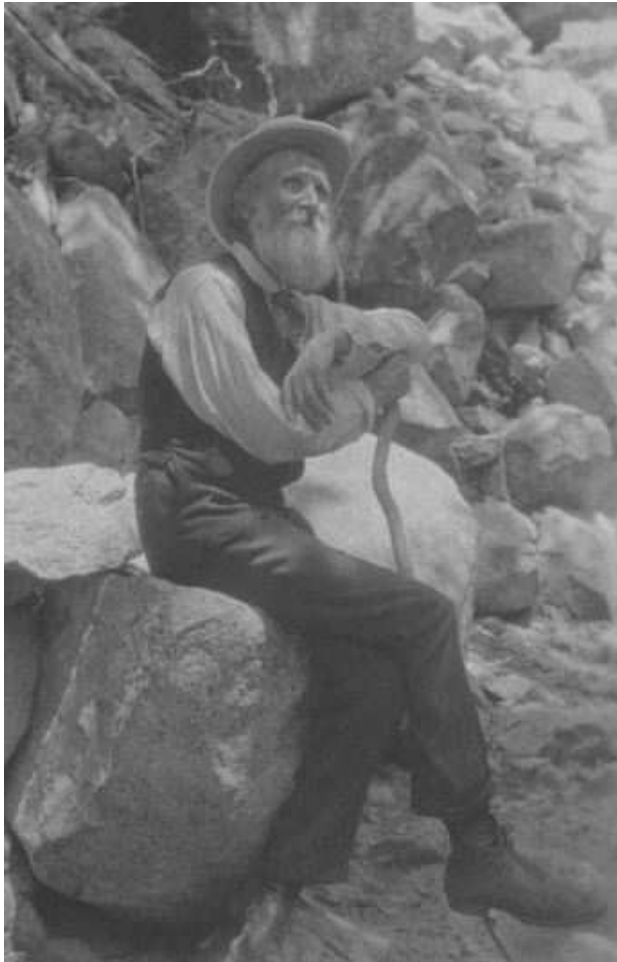
Inherent System Reliability

- An attribute of the design of the system
- Defines the maximum available reliability

Culture

- A characterization of how the system is performing relative to its inherent reliability
- A measure of system degradation

System design...Safety Culture



System Design...Safety Culture



Comments?



The single greatest impediment to
error prevention in the medical industry is
“that we punish people for
making mistakes.”

Dr. Lucian Leape
Professor, Harvard School of Public Health
*Testimony before Congress on
Health Care Quality Improvement*

References

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- The Joint Commission (2007) Creating a Fair and Just Culture: One Institution's Path Toward Organizational Change